بسم الله الرحمن الرحيم

عنوان المحاضرة: Face Presentation
تاريخ المحاضرة : 23/5/2013
المحاضر :د. محمد عبد الله

Definition:
It is a cephalic presentation in which the head is completely extended.

Incidence: 1:300
(Remember: ● 1:30→ Breech at term ● 1:3000→ Brow Presentation)

Etiology:
A) Primary face:
-It is diagnosed during pregnancy.
-It is usually due to fetal causes which may be:
1-Congenital Anomalies:
- Anencephaly: absence of the bony vault of the skull and the scalp while the facial portion is normal.
- Dolicocephaly: long antero-posterior diameter of the head, so as the breadth is less than 4/5 of the
- Tumors of the fetal neck e.g. congenital goiter

2-Loops of the cord around the neck
3-IUFD: due to lack of tone of flexor muscles
4-Large sized fetus
5-Multiple Pregnancy

B) Secondary face:
-It occurs during labor
-It is due to: Further deflexion of occipitoposterior position in the following cases: (4 P)
1-Contracted Pelvis 2-Pelvic Tumor 3-Placenta Previa 4-Pendulous abdomen

Presentation: Relation of the denominator to the maternal pelvis
The denominator in Face presentation is the mentum (chin)
**Remember

The denominator: is a bony landmark on the presenting part used to denote the position ●Vertex→ the occiput ●Face → the mentum (chin) ●breech→ the sacrum ●Shoulder→ the scapula ●Brow→ Frontal Bone

Positions: -Right mento-posterior -Left mento-posterior -Right mento-anterior -Left mento-anterior
**Anterior position (80%) is more common than posterion (20%), as face presentation usually results from occipitoposterior position

Diagnosis:
I) During Pregnancy
A) History: -Mento-anterior: Patient may feel fetal movements on both sides
B) Examination:
Inspection: -Feel movements on both sides
-Subumblical groove: present in (Mento/Occipito/Sacro) Posterior
Palpation:
-Fundal level: corresponds to the period of amenorrhea -Fundal grip: the breech is felt
-Umbilical grip: ●Mento-ant.→ back can't be felt ●Mento-post.→ back is felt in its upper part
-1st Pelvic grip: ●Mento-ant.→ a horseshoe shaped swelling (sinciput)
●Mento-post.→ a big bulk of the head is felt above the brim
Auscultation: ●Mento-ant.→ FHS is heard very well ●Mento-post.→ FHS can't be heard
C) Ultrasound: confirms the diagnosis and may identify associated fetal anomalies as anencephaly.
II) During Labor:
Vaginal Examination: Feel (Supraorbital margin – Nose – Alveolar margin – CHIN)

Differential Diagnosis:

*Late in labour, the face becomes edematous so it can be misdiagnosed as a buttock (breech presentation) where the two cheeks are mistaken with buttocks and the mouth with anus and the malar processes with the ischial tuberosities.

Face Presentation	Frank Breech
Fundal grip: the breech is felt	The head is felt
Less resistance of the opening (mouth)	More resistance of the opening (anus) Finger may be meconium stained
Mouth & malar processes form a triangle.	anus is on the same line with ischial tuberosities
The gum is felt hard through the mouth.	No hard object through the anus.

Mechanism of Labour

1-Descent

2-Engagement by submento-bregmatic diameter 9.5 cm

3-Increased extension

4-Internal rotation of chin: (in order to hinge the submental region below the symphysis)

- Mento-anterior → 1/8 circle anteriorly
- Mento-posterior → 3/8 circle anteriorly

5-Flexion: is the movement by which the head is delivered

6-Restitution: (the head points towards the side to which it was directed at the beginning of labor)

7-External rotation: in the same direction of restitution

**In the mento-posterior position:

-Delivery is by normal mechanism is 40% while delivery is by abnormal mechanism is 60% in which one of the following may occur:

1-Deep transverse arrest of the face: when the chin rotates 1/8 circle anteriorly

2-Persistent mento-posterior: when no rotation occurs

3-Direct mento-posterior: When the chin rotates 1/8 circle posteriorly

►no further progress occurs and labor is obstructed

**Direct mento-posterior, unlike direct occipito-posterior, cannot be delivered because:

(Delivery should occur by extension while the head is already maximally extended)

Management of Labor:

1-Exclude contracted pelvis (if so → CS)

2-In mento-anterior: Spontaneous delivery usually occurs

3-In mento-posterior: if failure of 3/8 rotation occurs:

- Caesarean section: it is the role in modern obstetrics
- Obsolete methods:
  - -Manual rotation and forceps
  - -Rotation and extraction at once by Kielland forceps
  - -Craniotomy: if the fetus is dead

**Ventouse is absolutely contraindicated as there is no structure to attach it to

**Indications of CS in face presentation:

1-Contracted pelvis 2-Direct mento-posterior 3-Fetal distress

4-Other obstetrics conditions (e.g. cord prolapse, long term infertility, elderly gravida)

Prognosis:

-Fetal mortality: 10-15% due to:

- Congenital malformations
- Cord prolapse
- Asphyxia from prolonged labor
- Operative interference
- Edema of the glottis

-Increased maternal morbidity due to:

- Exhaustion from prolonged labor
- Perineal tears
- Intrauterine infections
- Ruptured uterus

Brow presentation:

Definition: It is a cephalic presentation in which the head is midway between flexion and extension

Incidence: 1:3000

Etiology: As face presentation

Denominator: Frontal bone

Positions: Right, Left, Anterior & Posterior

Diagnosis:

A) During pregnancy: as face presentation

B) During labor:

In Vaginal examination: feel (frontal bone, root of nose, supraorbital ridges but **NOT** the chin)

NO Mechanism of Labor:

The engagement diameter is the mento-vertical 13.75 cm which is longer than any diameter of the inlet

Management: Cesarean section